

PREGNANCY IN RUDIMENTARY HORN OF UTERUS—5 YEAR ANALYSIS

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SUMMARY

Nine cases of pregnancy in rudimentary horn of uterus are analysed as regards the incidence, age and parity distribution.

The clinical features, diagnostic difficulties, course of pregnancy and treatment adopted are discussed.

Introduction

Pregnancy in the horn is a rare occurrence but with serious consequences. It was first described by Mauriceau and Vassel in 1669. Sporadic cases have been reported by various authors from time to time with various complications.

Material and Methods

All cases of pregnancy in the rudimentary horn that were admitted into the Government Rajaji Hospital, Madurai, from June 1979 to June 1984 were analysed as regards the incidence, age, parity, clinical features, laparotomy findings and management.

Incidence

During this 5 year period out of a total 295 cases of ectopic gestations, there were 9 cases of pregnancy in rudimentary

horn, thus pregnancy in rudimentary horn forming 3.05% of all ectopic pregnancies.

55.6% of these (9 cases) were in the age group 16-25 years, 33.3% between 26-35 years and 11.1% over 33 years. The youngest was 16 years and the oldest was 36 years.

66.7% were primigravidae, 2nd, 3rd and 5th gravida were 11.1% each with previous good obstetric history. The primigravidae were married from 5 months to 10 years. Long period of infertility was not the usual feature.

Period of pregnancy on admission varied from 14 weeks to 33 weeks.

Amenorrhoea was a feature in 8 out of 9 cases. All cases of ruptured rudimentary horn pregnancy reported with pain in abdomen of acute onset. Pain was absent in 1 case mistaken for secondary abdominal pregnancy and another who reported for Medical Termination of pregnancy.

All the 6 cases of rupture were in a state of shock with evidence of intra-

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peritoneal haemorrhage. Culdocentesis was positive in all cases. The general condition was good in the remaining 3 cases.

Ruptured rudimentary horn pregnancy was misdiagnosed as ruptured tubal gestation in 4 and rupture uterus, whereas unruptured pregnant horn was mistaken for ovarian tumour in 1 normal pregnancy and secondary abdominal pregnancy in 1. In all cases, diagnosis was confirmed at laparotomy by noting the relationship of the round ligament, fallopian tube and ovary to the pregnancy sac.

Mode of termination

Rupture of the pregnant horn was the commonest sequelae in 6 cases, missed abortion at 16 weeks in 1, foetal death at 30 weeks in 1 and recent death of the foetus after instillation 20% saline in 1. Period of rupture varied from 14-33 weeks of gestation.

Treatment adopted is outlined in Table

TABLE I
Treatment Adopted

Sl: No.	Treatment	No. of cases	Percentage
1.	Resection of the	4	44.4
2.	Resection of the horn with S.O.	4	44.4
3.	Hysterectomy	1	11.1

Mortality

There was a single death in this series in a patient admitted with irreversible shock.

Subsequent pregnancies

Out of the 8 patients who were alive 1 patient had concurrent tubectomy and

another patient hysterectomy. Two primigravidae were seen within few months of this analysis. In the remaining 4, 2 primigravidae had 1 full term delivery within one year and 3 months, a second gravida had 2 term deliveries within 4 years and one was lost to follow-up.

Discussion

The incidence of pregnancy in rudimentary horn of uterus has been variously reported as 0.1%, (Jarcho, 1949) to 2.3% (Bhattacharjee, 1977) of all ectopic gestations. Ours being a referral hospital, the incidence may be expected to be high.

The exact mode of nidation of the ovum in the rudimentary horn is controversial. The mucus membrane of the rudimentary horn communicated with the uterus through a minute canal in 20% (Mathur 1982). No demonstrable communications existed in any of our cases but none were subjected to histopathological examination.

All our cases were diagnosed only at laparotomy. In early pregnancy ruptured horn may be mistaken for ruptured tubal gestation but unlike in the latter condition, symptoms of rupture occurs as late as the 4th-5th month of pregnancy.

An unruptured pregnant horn may be misdiagnosed as ovarian tumour, normal pregnancy or pedunculated myoma but amenorrhoea of more than 16 weeks the extreme mobility, and the thickness of the pedicle connecting it to the main corpus should arouse suspicion. In secondary abdominal pregnancy again, the gestational sac will not be mobile due to the adhesions to the omentum and bowels and this should help in diagnosis.

The usual mode of termination of pregnancy is by rupture. The period at which rupture occurs is 16-20 weeks.